

PART 1

CONTACT:

ORGANIZATION NAME:

DHONE MILIMADED.

ORGANIZATION INFO (PLEASE COMPLETE ALL FIELDS)

School-Based Vaccine Order Form FOR HEALTH CARE PROVIDERS

PHONE NOWBER.			FAX INUIVIDER.						
PART 2	STUDENT INFO	(PLEASE COI	MPLETE ALL FIELD	S)					
LAST NAME:		FIRST NAME:				GRADE:			
DATE OF BIRTH:		OHIP: SCHOOL:							
PART 3 VACCINE ORDER (SELECT PROPER AGENT(S) AND DOSE # FOLLOWING VACCINE ELIGIBILITY CRITERIAS)									
AGENTS		STUDENT	VACCINE ELIGIBILITY			DOSE #			
(BRAND NAME)		AGE	VACCINE ELIGIDIETT				REQUESTED		
HB ADULT (1.0 mL)			• 11 to 15 years of age.					○ 2	
(Engerix® or Recombivax®)			Healthy individuals in grade 7 to 12.						
HB PEDIATRIC (0.5 mL)			• 16 to 19 years of age.				\bigcirc 1	○ 2	\bigcirc 3
(Engerix® or Recombivax®)			Healthy individuals in grade 7 to 12.				0-		
Men-C-ACYW-135			Healthy individuals in grade 7 to 12.				\bigcirc 1		
(Nimenrix® or Menactra®)			Those born in or after 1997.						
					rade 7 to 12 stude				
HPV-9			are < 15 years of age (or if 1 st dose given before age 15). • Three dose series: Healthy grade 7 to 12 students who					\bigcirc 2	\bigcirc 2
(Gardasil-9®)					•	dents wno	01	<u></u>	\bigcirc 3
			are ≥15 years of age when series started OR Immunocompromised grade 7 to 12 students.						
24.27.4	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						CLIDA	- TO DOD	> \
		NISTRATION	RATION (ONCE VACCINE(S) ADMINISTERED, COMPLETE PART 4 AND SUBMIT TO RCDHU						JHU)
Λ.	CENTS	DOCE #		EVDIDY	DATE CIVEN			DANOE	D A B 4 A
	GENTS ND NAME)	DOSE # GIVEN	LOT#	EXPIRY DATE	DATE GIVEN (YYYY/MM/DD)	GIVEN BY		PANOF ENT	
(BRA	ND NAME)		LOT#		DATE GIVEN (YYYY/MM/DD)	GIVEN BY			
(BRA	ND NAME)		LOT#			GIVEN BY	ONLY		
(BRA) HB ADULT (Engerix® c	ND NAME) (1.0 mL)		LOT#			GIVEN BY	SE ONLY		
(BRA) HB ADULT (Engerix® c	ND NAME) (1.0 mL) or Recombivax®)		LOT#			GIVEN BY	U USE ONLY		
(BRA) HB ADULT (Engerix® c	(1.0 mL) or Recombivax®) RIC (0.5 mL) or Recombivax®)		LOT#			GIVEN BY	DHU USE ONLY		
(BRAI HB ADULT (Engerix® c HB PEDIAT (Engerix® c Men-C-AC	(1.0 mL) or Recombivax®) RIC (0.5 mL) or Recombivax®)		LOT#			GIVEN BY	RCDHU USE ONLY		
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EMAIL:

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